STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING _____	01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE REHABILITATION & HEALTH CARE CENT	8181 HARCOURT ROAD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/27/11 Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Harcourt Terrace Rehabilitation & Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (211) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 116 and had a census of 68 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 01/28/11. APPROVED 3/1/11 DA The facility was found not in compliance with the	K 000	**Preparation and/or execution Of this plan of correction in General , or this corrective Action in particular, does Not constitute an admission Or agreement by this facility Of the facts alleged or Conclusions set forth in this Statement of deficiencies. The plan of correction and Specific corrective actions Are prepared and/or Executed in compliance With state and federal laws.** RECEIVED FEB 16 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 2-14-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING _____	01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE REHABILITATION & HEALTH CARE CENT	8181 HARCOURT ROAD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 aforementioned regulatory requirements as evidenced by the following:	K 000	**KO29—NFPA-101 Life Safety Standard—Door**	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 2 doors serving hazardous such as the laundry room closed and latched to prevent the passage of smoke. This deficient practice could affect any staff or visitor in the vicinity of the basement laundry room. Findings include: Based on observation with the Maintenance Supervisor during the tour of the facility from 10:40 a.m. to 12:35 p.m. on 01/27/11, the soiled linen laundry room door failed to close and latch into the door frame. The soiled linen laundry room door is held open by a magnetic device arranged to automatically close upon activation of the fire alarm system. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the soiled linen laundry room door	K 029	**It is the intent of this facility To ensure all doors serving Hazardous such as the Laundry room close and Latch to prevent the Passage of smoke.** **I: Actions Taken The foor/frame were Immediately adjusted To ensure the door Closed and latched.** **II: Residents Affected: Residents do not have Access to the basement Area therefore there Were no residents Affected.** **III: Measures Taken: The maintenance staff Installed an automatic Door closure on this Door to ensure the Door is closed and Latched.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING _____	01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE REHABILITATION & HEALTH CARE CENT	8181 HARCOURT ROAD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 2 was contacting the edge of the door frame at the base of the door frame and would not close and latch if the fire alarm system was activated. Based on interview at the time of observation, the Maintenance Supervisor acknowledged residents do not have access to the basement. 3.1-19(b)	K 029	**IV: Monitoring** **The maintenance Dir. Or Designee will monitor This door during Monthly PMs on Going and will bring Findings to the monthly QA&A committee for Review and follow up.** **V: This plan of correction Constitutes our credible Allegation of compliance With all regulatory Requirements. Completion Date: 1/28/11.**	1-28-11